times we have brought it up. We are ready to vote again if that is what we need to do.

(The remarks of Mr. ALEXANDER pertaining to the introduction of S. 3326 are printed in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, I ask unanimous consent to speak, I suppose out of turn. I understand the Republicans, the majority, have control of the floor. I ask unanimous consent to speak for 10 minutes, since there are no other majority Senators.

The PRESIDING OFFICER. Is there objection?

Mr. ALEXANDER. Mr. President, through the Chair, may I ask a question, which would be that Republican minutes will be——

The PRESIDING OFFICER. Will the Senator state his inquiry?

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Republican minutes be preserved for Senator THUNE.

The PRESIDING OFFICER. Will the Senator from Delaware so modify his request?

Mr. CARPER. I am not sure what the Senator from Tennessee is saying.

Mr. ALEXANDER. Mr. President, following the Senator from Delaware, I ask unanimous consent that whatever Republican minutes are remaining would be reserved for Senator THUNE.

Mr. CARPER. That will be fine. I have absolutely no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ALEXANDER. I thank the Senator from Delaware for his courtesy.

Mr. CARPER. I thank the Senator from Tennessee. As he knows, I am a huge fan of his. I have been for a long time. I respect him as a colleague, I respected him as a Governor, and I respected him long before that when he was a principal aide to Howard Baker, who was one of the greatest Senators who served in this body in the last century.

He and I agree on a lot. We work on a lot of things together, and it has been a source of real joy for me.

AFFORDABLE CARE ACT

Mr. CARPER. Mr. President, I like to tell the story about a Senate Finance Committee hearing about 2 years ago when we had a bunch of very smart people who came in to talk to us about this: What are we going to do about reducing the deficit?

We continue to reduce the deficit. We peaked out at $1.4 trillion about 6 or 7 years ago. We are down to about $400 billion now; it is still way to high. But the hearing was designed to ask: What are some things we can do to further reduce our budget deficit?

One of our witnesses was a fellow who used to be Vice Chairman of the Federal Reserve, Alan Blinder. At the time he testified 2 years ago, he was back at Princeton teaching economics.

As a witness before our committee on reducing Federal budgets, he said: The 800-pound gorilla in the room on health care, on deficit reduction, is health care costs. That is what he said. That is the biggest one—Medicare, Medicaid, the VA system, and so forth. He said that is where the money lies; that is where we have to focus.

When it came time to ask questions of our witnesses, I asked Dr. Blinder: You mentioned that health care is the 800-pound gorilla in the room on deficit reduction. What do you think we ought to do?

He sat there for a while, he sat there for a while, and he sat there for a while. Finally, he said these words: I am not an expert on health care. I am not a health economist, but if I were in your shoes, here is what I would do. I would find what works and do more of that.

That is all he said.

I said: Do you mean to find out what doesn't work and do less of that?

He said: Yes.

If you go back—oh, Lord, this is 2016. If you go back about 22 years in our Nation's history, there was a big debate on Capitol Hill on an idea actually proposed and put forward by the First Lady of our country, Hillary Clinton. She proposed—not ObamaCare; she worked on something that was called HillaryCare. But the idea we had—like a lot of people in this country who were not covered by health insurance—millions, tens of millions of them—we spent way more money in America on health care costs than just about any other developed Nation. We didn't get better results.

Every President since Truman has basically said that we have to do something about extending health care coverage to people who don't have it and trying to make sure it is affordable. Nobody really came up with anything. So the First Lady of this country, of all people, said: Well, I am going to work on this.

And she went to work on it. She came up with a proposal called HillaryCare. It was ultimately not adopted, but our Republican friends, as they should have, came up with an alternative to HillaryCare.

One of the key components of their proposal was something that actually looks a lot like ObamaCare. What they came up with was this idea of creating health care exchanges or purchasing pools, large purchasing pools, that people who don't have health care coverage could elect to join.

As with thousands, maybe tens of thousands, even hundreds of thousands of people from their States, these State-by-State purchasing pools or exchanges could provide the opportunity for people who don't get health care coverage, are not part of a large purchasing pool, and don't work for a big employer who provides health care coverage—they could derive the same advantages as those who do have that kind of employment opportunity. That was the Republican alternative.

At the end of the day, it didn't go anywhere. But at the time I thought that was a good idea.

I wasn't here at that time. I was Governor of my State and very active in the National Governors Association. I said: I think these Republicans have a good idea, creating these exchanges, these large purchasing pools, and maybe providing a tax credit from the Federal Government to buy down the cost of premium coverage.

But neither idea ended up flying. HillaryCare ended up going away. The Republican alternative, which was a lot like ObamaCare today, was not enacted.

Fast forward to 2009, with a new President who wanted to finally do something about reining in health care costs, covering people who didn't have coverage—tens of millions of people—and trying to figure out: How do we bring down not only the cost of health care, but how do we get better results?

At the end of the day, a white paper was issued for those of us on the Finance Committee to consider as we took up our debate in 2009. The way negotiations ended up proceeding, in order to try to find a starting point, was to work from the white paper on health care reform but then have three Democrats and three Republicans who would join one another. These were senior members of our committee who were very good at finding the middle, very good at finding consensus. The idea was for them to try to negotiate an agreement, a bill. They tried not just for days, not just for weeks, but for months.

I am a pretty bipartisan guy around here, but I am not sure there was a real bipartisan intent to get to a compromise. I would not cast aspersions, but I think there is probably a little more blame to lie on the other side of the aisle than on this one.

As Democrats, we pretty much decided to put something together, and we took two good Republican ideas. One of those is these large purchasing pools, these exchanges. We said every State should have one and give the opportunity for people to be part of a larger purchasing pool if they don't have health care coverage—if they don't work for an employer that provides health care coverage—to get the advantage of buying health care coverage in bulk, if you will, and having a stronger negotiating position, more leverage.

That was the Republican idea. I thought it was a good idea in 1994, and, frankly, as a member of the Finance Committee, I thought it was a good idea in 1999.

Another good Republican idea that was put forward at the time was the individual mandate. That is not a Democratic idea; that was an idea that came from Governor Romney in Massachusetts, where they put in place their

own RomneyCare plan, which has actually worked pretty well. They have purchasing pools just as we do in States across the country—these exchanges. But they also have something in place that is an individual mandate if somebody didn't get coverage. They want everybody in Massachusetts to be covered. But if they elected not to be covered, after 1 year or 2 years or 3 years, people just said: I am not going to get coverage. I am young, I am invincible, and I don't need health care coverage. I can't afford it—even with the tax credit they received through RomneyCare. They said: You are going to have to pay a tax or a fee if you don't get coverage, if you will not sign up. You can't just get away with it. You are going to have to pay something.

The idea was to have an escalating fee so that eventually people would say: You know, it is one thing to be fined or taxed a $100 tax if I don't sign up for health care coverage, but how about when it is $300, $500, $700, $800 a year? So eventually people signed up.

In this country, as well, we have the exchanges, which actually were a gift from our Republican friends. I think it was a good idea then and now.

We also have the individual mandate, which is gradually ramping up so that the young invincibles, the young people who are not getting health care coverage, will get coverage. As more younger, healthier people join the purchasing pools, the idea will be that it will bring down the cost of health care coverage overall so it is not just the sick, the elderly, but it is a healthier group of people.

That is sort of where we are today. The idea of pulling the plug on the Affordable Care Act or significant parts of it because a principal component of it—and that is the purchasing pools, these exchanges—is not working as advertised would be a mistake. If it isn't perfect, make it better.

We had a chance in 2009 to negotiate a real bipartisan health care reform plan. Unfortunately, we didn't do that. We are going to have a chance again in the early part of next year with a new President and a new Congress to again take up that which is flawed, which is imperfect, and that is the Affordable Care Act, to make it better—not to get rid of it, but to make it better.

Senator ALEXANDER is a very wise and highly regarded colleague. He may have a very good idea. I just heard about it here on the fly today. But my hope is that Lamar and the rest of us who want to get things done, to do our job, will seriously take this challenge that is before us and take that original good Republican idea from 1994 on the exchanges, create purchasing pools, and make it better. We should take a look at the individual mandate that Governor Romney adopted in Massachusetts and see how that is working and look at other exchanges as well.

The long-and-short story is that when we took up the Affordable Care Act in 2009, here is where we were as a country: We were spending 18 percent of GDP for health care costs. In Japan they spent 8 percent. We were spending 18 percent of GDP; they were spending 8 percent. They were getting better results, longer life, longevity, lower infant-mortality rates, and they covered everybody. They covered everybody in 2009.

Where were we? We were spending 18 percent of our GDP. We didn't cover—we had 40 million people going to bed at night without any health care coverage at all. One of the reasons the cost of coverage has gone pretty high right now for people in these new exchanges and purchasing pools is that a lot of the people who are signing up—not all of them, but a lot of them—haven't had health care coverage for years. They have been sick, and they have just not had access to doctors or nurses, except for going to an emergency room doctor.

This is not a time to just throw up our hands and walk away. This is a problem. This is a problem we can fix. I would say we can fix it by embracing what I call the three Cs: communicate, compromise, and collaborate. We need to embrace those when this Congress is over.

ZIKA VIRUS FUNDING

Mr. CARPER. Let me just add a P.S. on Zika funding, which was discussed here earlier today. We had a bipartisan roundtable in the Homeland Security Committee on Zika funding not long ago. Two reasons we need to resolve this funding issue are, No. 1, that we would have money to continue development of a vaccine—that is the single most important thing—and, No. 2, to provide for contraception and family planning. Those are two of the most important things for us to do as we try to avoid this endemic.

I thank my Republican friends for allowing me to speak on their time.

With that, I yield the floor.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER (Mr. SULLIVAN). The majority leader is recognized.

EXTENSION OF MORNING BUSINESS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that morning business be extended until 12 noon today.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

MEASURE PLACED ON THE CALENDAR—S. 3318

Mr. MCCONNELL. Mr. President, I understand there is a bill at the desk due a second reading.

The PRESIDING OFFICER. The clerk will report the bill by title for the second time.

The senior assistant legislative clerk read as follows:

A bill (S. 3318) to amend the Consumer Financial Protection Act of 2010 to subject the Bureau of Consumer Financial Protection to the regular appropriations process, and for other purposes.

Mr. MCCONNELL. In order to place the bill on the calendar under the provisions of rule XIV, I object to further proceedings.

The PRESIDING OFFICER. Objection having been heard, the bill will be placed on the calendar.

OBAMACARE

Mr. MCCONNELL. Mr. President, let me start by stating the obvious: ObamaCare is a direct attack on the middle class. Premiums are shooting up by double digits, copays are spiking, and deductibles are skyrocketing. Co-ops are collapsing and insurers are withdrawing.

We all know the statistics, and they are literally shocking. Yet they still do not truly capture the toll this partisan law is taking on America's middle class, because behind every premium increase headline is a family budget stretched to its limits, and beyond every co-op collapse is an agonizing uncertainty about where a family will find insurance. This is what too often gets lost in the debate over ObamaCare, especially amongst our Democratic friends, perhaps because it helps them rationalize away the pain of this law. But this is not some theoretical discussion; these are people's lives this law is hurting.

That is why I shared the story of a mom in Louisville who said her family's health care costs would consume nearly a fifth of their budget this year. ''I wish somebody would explain to us,'' she wrote, ''how a hard working middle class family paying this much for health insurance became a loser under Obamacare.''

That is why I shared the story of the Campbellsburg man who had just lost the health insurance he had had for many years. ''Instead of something affordable,'' he wrote, ''I [now] face the possibility of struggling to purchase an Obama[care] health plan that costs two to three times what I had been paying.''

That is why I shared the story of a small business man in Lexington who may have to end his decades-long practice of providing insurance to his employees at no cost thanks to, as he wrote, ''the cynically named Affordable Care Act.''

I shared stories from other States too. There is the New Jersey man with chronic health issues who lost access to his doctor the moment ObamaCare placed him on Medicaid. ''You have a card saying you have health insurance,'' he said, ''but if no doctors take it, it's almost like having one of those